STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243
www.tennessee.gov

TENNESSEE BOARD OF MEDICAL EXAMINERS
COMMITTEE ON PHYSICIAN ASSISTANTS

(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384

APPLICATION INSTRUCTIONS FOR LICENSURE AS A PHYSICIAN ASSISTANT
LICENSURE APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Committee.**

ALL APPLICATION FEES ARE NON-REFUNDABLE.

		Done
1.	Complete, have notarized, and mail the application pages 1 through 6.	
2.	Attach to the application a clear, recognizable, recently taken, signed and notarized passport photograph of yourself.	
3.	Complete and mail Attachment1 to the institution at which you completed your physician assistant program.	
4.	If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a physician assistant or other health professional, you must complete and mail Attachment 2 to each and every state. Copies of Attachment 2 may be duplicated to accommodate each request.	
5.	If you are certified by the national Commission on Certification of Physician Assistants, you must complete and mail Attachment 3 to the NCCPA.	
6.	If you have a supervising physician, submit Attachment 4 along with your application. Attachment 4 must be signed by the supervising physician and must be submitted prior to beginning practice.	
7.	If completing Attachment 5, one (1) copy must be mailed to our office and a copy must be mailed to the Tennessee Board of Pharmacy, Second Floor, Volunteer Plaza, 500 James Robertson Parkway, Nashville, TN 37243-1149.	
8.	Submit two (2) original letters of recommendation on letterhead from medical professionals who can attest to your character as a physician assistant. These letters must identify the individuals as medical professionals and **must be originals** on signatory's letterhead.	
9.	Please complete the enclosed practitioner profile questionnaire and mail back with the application for licensure.	
10.	Attach to the application a check or money order in the amount of $335 made payable to the Committee on Physician Assistants. If requesting temporary certification or temporary authorization, attach to the application a check or money order in the amount of $385. All fees are non-refundable.	
11.	If your supervising physician authorizes you to prescribe controlled drugs you must have a Federal Drug Enforcement Administration (DEA) number. A DEA number may be obtained by calling (800) 882-9539.	
12.	Effective June 1, 2006 applicants for initial licensure in Tennessee must obtain a criminal background check. **Click here for instructions**.	

UNDERSTANDING THE APPLICATION PROCESS

1. **All application fees are non-refundable.**

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

   Tennessee Board of Medical Examiners
   Heritage Place Metro Center
   227 French Landing, Suite 300
   Nashville, TN 37243 (37228 for courier service only)

3. **Allow fourteen (14) working days** for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.

4. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board office sixty (60) days from the date of the initial deficiency letter. **(Files not completed within sixty (60) days will be closed.)**

5. Absent any complicating factors, the average application processing time is six (6) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.

6. **If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.**

7. It is recommended that you do not make arrangements to accept employment as a physician in Tennessee until you are granted a license, temporary certificate, or temporary authorization by the Committee on Physician Assistants.

8. All practicing PAs must have a written protocol outlining the range of services under which they practice in their respective medical communities.

Thank you for your cooperation. We will make every effort to work your application in a timely manner.

For Office Use Only

3628-001	$325
3628-006	$ 10
	$335
3628-001	$375
3628-006	$ 10
	$385

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
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BOARD OF MEDICAL EXAMINERS
COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384

APPLICATION FOR LICENSURE

Choose the appropriate licensure category for which you are applying. Check the appropriate subcategory which applies to your application. See the Practice Act and the rules and regulations to determine the requirements for each category of practitioner and temporary certification.

_____ Physician Assistant Licensure by Exam or Reciprocity (attach $335 payment)

_____ Apply with request for temporary certificate (attach $385 payment)

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name as it will appear on license: _____
(*First*) (*Middle*) (*Last*)

Social Security Number: _____ Date of Birth: Mo. ____ Day ____ Yr. _____

Present Mailing Address: _____ Home Phone: (_____) _____ - _____

_____

_____ Work Phone: (_____) _____ - _____

Place of Birth: _____ Sex: (optional, for statistical purposes only)
Female _____
Male _____

U. S. Citizen: Yes___ No____

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. (SEND **ATTACHMENT #1** TO THE EDUCATIONAL INSTITUTION WHERE YOU COMPLETED YOUR PROGRAM)

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Inst./Phys. Asst. Program Location

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Inst./Phys. Asst. Program Location

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Inst./Phys. Asst. Program Location

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Inst./Phys. Asst. Program Location

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES **LOCATION**

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

LICENSURE INFORMATION

List below all states, countries, provinces in which you have ever been or currently are licensed, permitted, or certified as a Physician Assistant. Submit a copy of **Attachment 2** to all such states, countries, or provinces regarding such licensure, certification, or permit. Us the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL** state, countries, or provinces in which you hold or have ever held a license as a health professional other than a Physician Assistant. Submit a copy of attachment #2 to all such state, country, or province regarding such licensure. Additional pages may be added if necessary.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

		Yes	No
1.	Are you certified (NCCPA) by the National Commission on the Certification of Physician Assistants? If so, complete **Attachment 3** and send it to the NCCPA.	____	____
2.	Have you ever applied for a physician assistant license in Tennessee?	____	____
3.	Have you ever received a temporary permit or license in Tennessee?	____	____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** to be construed to include all of the following:

   a. The cognitive capacity to exercise reasoned professional judgments, to learn, and keep abreast of developments in your profession;

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g., heroin, or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	____	____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	____	____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	____	____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS:		YES	NO
2.	Do you currently use chemical substances?		
	If yes, do they in any way impair or limit your ability to practice medicine with reasonable skill and safety?		
	Please list: _____		
3.	Are you currently engaged in the illegal use of controlled substances?		
	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?		
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?		
5.	If you have ever held or applied for a license or certificate to practice medicine in any state, country, or province, has or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?		
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? *		
7.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?		
8.	Have you ever been rejected or censured by a professional society?		
9.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered <u>against</u> you; *		
	b. Have you ever had settlement of any legal action rendered <u>against</u> you; or *		
	c. Are there any legal actions pending <u>against</u> you or to which you are a party?		
10.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? *		
11.	Have you ever failed a licensure or certification exam? If yes, please describe the circumstances: _____		

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, PA, of _____
(*Applicant's Name)* *(City)* *(State)*
being duly sworn and identified as the person referred to in this application attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of my profession in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Committee, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

AUTHORIZE the Committee, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Committee, the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me this _____ day of _____, 20____

_____ Affix Seal Here
NOTARY PUBLIC

My Commission expires _____

ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your physician assistant program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee..

Full Name: _____
(Last) (First) (Middle/Maiden)

Address: _____ Social Security Number: ___ - ___ - ___

_____

_____

_____

Student Identification Number: _____

Year of Graduation: _____

Degree Obtained: _____ Date Degree Conferred: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a physician assistant in the State of Tennessee. Please forward an original graduate transcript of courses, grades, and degree bearing the institution's official seal to:

Board of Medical Examiners
Committee on Physician Assistants
Heritage Place Metro Center
227 French Landing, Suite 300
Nashville, TN 37243 (37219 for courier service only)

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

ATTACHMENT 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384
www.tennessee.gov

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (You may copy this form.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

_____ was granted a license to practice _____
(Name of Applicant) *(Profession)*
with license number _____ on _____ in the State of _____.
(Date)

The Committee on Physician Assistants of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

Committee on Physician Assistants
Heritage Place Metro Center
First Floor, Cordell Hull Bldg.
Nashville, TN 37243

Date: _____

_____
Applicant's Signature

_____
Applicant's typed or printed name

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:

Name In Full As It Appears On License:

License Number _____ Profession _____ Date Issued _____

Basis of issuance: (Check One) _____ Endorsement/Reciprocity with _____ (State)

_____ Written Examination _____ (Name of Exam)

The License is currently active and registered? Yes _____ No _____
Is there any derogatory information on file? Yes _____ No _____ If yes, an explanation must be attached.

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384
www.tennessee.gov

NCCPA VERIFICATION

Only if or when you are credentialed with the NCCPA, please complete this form and mail it to the address below:

NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS
12000 Findley Road, Suite 200
Duluth, GA 30097

To Be Completed By Applicant (Please Print In Ink)

Dear NCCPA Official:

I am applying for a license to practice as a Physician Assistant in the State of Tennessee. The State Board of Medical Examiners' Committee on Physician Assistants requires that a credential letter by **forwarded directly to their** office by the NCCPA.

Applicants Name: _____
(First) (Middle) (Last)

Social Security Number: _____ Credential #_____

PLEASE MAIL CREDENTIAL VERIFICATION DIRECTLY TO:

Committee on Physician Assistants
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, Tennessee 37243

ATTACHMENT 4 **Applicant's Name** _____

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384

SUPERVISING PHYSICIANS

This section must be completed by the supervising physician(s).
(This page may be duplicated if necessary)

List all practice settings:

1) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

2) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

3) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

4) Setting:

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

ATTACHMENT 5

TENNESSEE BOARD OF MEDICAL EXAMINERS' COMMITTEE ON PHYSICIAN ASSISTANTS

AUTHORIZATION FOR PRESCRIBING FOR PHYSICIAN ASSISTANTS

Supervising Physician _____

Address _____

_____

City State Zip Code

Phone Number _____

Field of Practice _____

Medical License Number _____

Physician Assistant _____

Field of Practice _____

Address _____

_____

City State Zip Code

Phone Number _____ TN License Number _____

Check the class of drugs you desire to delegate:

_____	Analgesics	_____	Enzymes
_____	Anesthetics	_____	Expectorants and Cough Preparations
_____	Antihistamines	_____	Eye, Ear, Nose, and Throat Preparations
_____	Anti-infective Agents	_____	Gastrointestinal Drugs
_____	Anti-inflammatory Agents	_____	Hormones and Synthetic Substitutes
_____	Anti-neoplastic Agents	_____	Hyperglycemic Agents
_____	Antispasmodics and Anticholinergics	_____	Migraine Preparations
_____	Antivirals	_____	Muscle Relaxant Preparations
_____	Arthritis Medications	_____	Narcotic Antagonists
_____	Autonomic Drugs	_____	Oxytocics
_____	Blood Derivatives	_____	Psychotropics
_____	Blood Formation and Coagulation	_____	Serum, Toxoids, and Vaccine
_____	Birth Control Drugs and Devices	_____	Skin and Mucous Membrane Preparations
_____	Bronchodilators/Anti-asthma Drugs	_____	Smoking Cessation Aids
_____	Cardiovascular Drugs	_____	Smooth Muscle Relaxants
_____	Central Nervous system Drugs	_____	Spasmolytic Agents
_____	Contraceptives	_____	Sympathomimetics and Combination
_____	Diabetic Agents	_____	Vitamins
_____	Diagnostic Agents	_____	Unclassified Therapeutic
_____	Decongestants	_____	Other _____
_____	Electrolytic, Caloric, and Water Balance		_____
			_____

Check the type **and** schedule of controlled drugs you desire to delegate:

Type		Schedule II	Schedule III	Schedule IV	Schedule V
_____	None	_____	_____	_____	_____
_____	Barbiturates	_____	_____	_____	_____
_____	Benzodiazepines	_____	_____	_____	_____
_____	Depressants	_____	_____	_____	_____
_____	Narcotics	_____	_____	_____	_____
_____	Stimulants	_____	_____	_____	_____
_____	Other (Please List)	_____			
		_____			
		_____			

I, _____ MD/DO, License Number _____
Please print

I, _____ MD/DO, License Number _____
Please print

I, _____ MD/DO, License Number _____
Please print

I, _____ MD/DO, License Number _____
Please print

do hereby delegate the above prescribing authority to _____ PA of whom I am the supervising physician and will assume the responsibility according to TCA §63-19-107.

I, _____ PA do hereby accept the delegated function of prescribing authorization and will utilize it as such according to TCA §63-19-107.

_____
Signature of Physician Assistant Date

_____
Signature of Supervising Physician Date

_____
Signature of Supervising Physician Date

_____
Signature of Supervising Physician Date

_____
Signature of Supervising Physician Date

G4010161

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWARD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health.

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider to</u>:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records</u>.**

✓CHECKLIST

Before you mail your questionnaire:

Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER:_____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(____)_____ **(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.
1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:
1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			

If "YES", is this conviction under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

If "YES", is this conviction under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

If "YES", is this conviction under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date: _____

(Signature of Provider)

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